APPEAL NO. 051298
FILED JULY 18, 2005

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on May 19, 2005. The disputed issues were the respondent's (claimant) impairment rating (IR) and entitlement to supplemental income benefits (SIBs) for the first quarter. The hearing officer resolved the disputed issues by deciding that the claimant's IR is 20% as reported by the designated doctor chosen by the Texas Workers' Compensation Commission (Commission), and that the claimant is entitled to SIBs for the first quarter. The appellant (self-insured) appealed, contending that the claimant's IR is 10% and that the claimant is not entitled to SIBs for the first quarter. The claimant responded, requesting affirmance.

DECISION

Affirmed as to the IR issue, and reversed and remanded as to the SIBs issue.

**IR ISSUE**

The parties stipulated that the claimant sustained a compensable injury on _____. The claimant injured his lower back on that day while working as a construction worker. The claimant underwent a lumbar fusion at L4-5 and L5-S1 in December 2002. The parties stipulated that the claimant reached maximum medical improvement (MMI) on October 31, 2003. The Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) apply to this case. The designated doctor appointed by the Commission reported that the claimant reached MMI on October 31, 2003, with a 20% IR under Diagnosis Related-Estimate (DRE) Lumbosacral Category IV: Loss of Motion Segment Integrity. The designated doctor noted that the claimant has a multilevel spine segment structural compromise due to a multilevel fusion at L4-5 and L5-S1, and that according to Commission Advisory 2003-10, signed July 22, 2003, a multilevel fusion meets the criteria for DRE Category IV. The claimant's treating doctor also reported that the claimant's IR is 20% under DRE Lumbosacral Category IV. The treating doctor noted that he used the Range of Motion model as a differentiator. A required medical examination (RME) doctor reported that the claimant has a 10% IR under DRE Lumbosacral Category III: Radiculopathy.

In response to a Commission letter of clarification, the designated doctor noted that there were no preoperative flexion and extension x-rays and that he chose to follow Commission Advisory 2003-10. The Commission sent a second letter of clarification to the designated doctor along with a copy of Texas Workers' Compensation Commission Appeal No. 042108-s, decided October 20, 2004, in which it is explained that under Commission Advisory 2003-10 and Commission Advisory 2003-10B, signed February

24, 2004, the assignment of an IR based on DRE Category IV for a multilevel spinal fusion is not required but is an option. The designated doctor's response to the second letter of clarification reflects that he understood that the application of Commission Advisory 2003-10 is not mandatory. The designated doctor noted that the utilization of Commission Advisory 2003-10 is appropriate in the claimant's case and that the 20% IR is appropriate.

The self-insured contends that Commission Advisory 2003-10 is invalid. The Appeals Panel stated in Appeal No. 042108-s, *supra*, that it does not have the authority to overrule the Commission advisories in question. Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary. The hearing officer found that the designated doctor's certification of a 20% IR is not contrary to the great weight of the other medical evidence, and concluded that the claimant's IR is 20%. We conclude that the hearing officer's determination that the claimant's IR is 20% is supported by sufficient evidence and is not so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. We affirm the IR determination.

**SIBs ISSUE**

Eligibility criteria for SIBs entitlement are set forth in Section 408.142(a) and Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.102 (Rule 130.102). Pursuant to Section 408.142(a), an employee is entitled to SIBs if on the expiration of the impairment income benefits (IIBs) period the employee: (1) has an IR of 15% or more from the compensable injury; (2) has not returned to work or has returned to work earning less than 80% of the employee's average weekly wage (AWW) as a direct result of the employee's impairment; (3) has not elected to commute a portion of the IIBs; and (4) has attempted in good faith to obtain employment commensurate with the employee's ability to work. The claimant has an IR of 15% or more from the compensable injury based on our affirmance of the hearing officer's determination that the claimant's IR is 20%. The parties stipulated that the claimant did not commute any portion of the IIBs. What we address here is the self-insured's appeal of the hearing officer's findings that the claimant met the direct result and good faith criteria for SIBs entitlement for the first quarter. It is undisputed that the qualifying period for the first quarter was from September 12 through December 11, 2004. The qualifying period is a period of time for which the employee's activities and wages are reviewed to determine eligibility for SIBs. Rule 130.101(4).

With regard to the direct result criterion, Rule 130.102(c) provides that an injured employee has earned less than 80% of the employee's AWW as a direct result of the impairment from the compensable injury if the impairment from the compensable injury is a cause of the reduced earnings.

With regard to the good faith criterion, it is undisputed that during the qualifying period the claimant did not work, did not search for employment, and was not in a

vocational rehabilitation program sponsored by the Texas Department of Assistive and Rehabilitative Services or by a private provider. The claimant contended that he had no ability to work as a result of his compensable injury during the qualifying period. Rule 130.102(d)(4) provides that an injured employee has made a good faith effort to obtain employment commensurate with the employee's ability to work if the employee has been unable to perform any type of work in any capacity, has provided a narrative report from a doctor which specifically explains how the injury causes a total inability to work, and no other records show that the injured employee is able to return to work. Rule 130.102(e) provides that except as provided in subsection (d)(1), (2), (3), and (4) of Rule 130.102, an injured employee who has not returned to work and is able to return to work in any capacity shall look for employment commensurate with his or her ability to work every week of the qualifying period and document his or her job search efforts.

The Commission initially determined that the claimant was entitled to SIBs for the first quarter and the self-insured disputed that determination by filing a request for a benefit review conference.

The claimant testified that he continues to have back problems with pain down his left leg, and that he is unable to work in any capacity. The claimant's treating doctor issued Commission Work Status Reports (TWCC-73) before, during, and after the qualifying period in which he indicated that the claimant's medical condition resulting from the compensable injury is such that the claimant has been restricted from all work. In a letter dated September 14, 2004, which was during the qualifying period, the treating doctor wrote that the claimant's diagnosis is chronic low back and left leg pain; that he is in constant pain and will not be able to perform any work duties; that he is unable to return to work of any kind; that he is unable to lift more than one pound; and that there is to be no repetitive bending or twisting. The treating doctor stated that he strongly disagreed with having the claimant return to light-duty work.

In a letter dated December 17, 2004, which was shortly after the qualifying period ended, the treating doctor wrote that the claimant has continuing lumbar pain with radiculopathy and that in his opinion the claimant would only be able to attempt a job where he could work four hours a day or less and did not have to drive more than five minutes to and from work, and that under these conditions, it would be nearly impossible for any person with the claimant's skills and training to have meaningful employment in the current job market.

In a letter dated March 18, 2005, the treating doctor wrote that the claimant has continuing complaints of severe lower back pain with pain radiating down the left leg into the left foot; that the constant pain is much worse when sitting, walking, or driving for greater than 15 minutes; that the claimant should not perform any lifting or carrying over one pound and should restrain from overhead reaching; and that kneeling, bending, stooping, pushing, pulling, or twisting seems to aggravate the back pain.

In a letter dated April 13, 2005, the treating doctor wrote that the claimant's compensable back injury and subsequent lumbar fusion have left the claimant in

constant severe low back pain radiating down the left leg; that the claimant had no ability to work at all during the qualifying period for the first quarter due to the work-related injury; that the claimant is functionally limited by his inability to lift, carry, kneel, bend, stoop, push, or pull; that sitting, walking, or driving for longer than 15 minutes are not possible for the claimant due to severe pain in the lumbar spine; and that the claimant's inability to work is directly attributable to the claimant's work injury.

A peer review doctor reviewed medical information sent to him by the self-insured and wrote in July 2003 that it seemed very reasonable for the claimant to be able to perform work in a limited capacity at that point in time. The peer review doctor again reviewed medical information sent to him by the self-insured and wrote in February 2004 that he would anticipate that the claimant could pursue sedentary work and that possibly a referral to the Texas Rehabilitation Commission for vocational training would be of assistance.

The self-insured's RME doctor examined the claimant on December 17, 2004, shortly after the qualifying period ended, and reported that the claimant had been sent for a functional capacity evaluation (FCE) that day, but that the RME doctor did not have the results of the FCE. The RME doctor wrote that the claimant is suffering from post-laminectomy syndrome and that in his opinion, without seeing the FCE, the claimant should be returned to work in a modified duty position, with limitations on lifting, bending, stooping, and other activities that would stress the lumbar spine, and should be allowed frequent breaks to change positions. The claimant said that he did not get the RME doctor's report regarding his ability to work until sometime after Christmas.

The FCE report of December 17, 2004, states in the "Assessment" section: "Physical Demand Level (PDL): As defined by the U.S. Department of Labor in the Dictionary of Occupational Titles they may be expected to perform at the sedentary level based upon dynamic lifting evaluations."

In a letter dated January 10, 2005, the RME doctor noted that he had reviewed the FCE report of December 17, 2004, and that "[t]here is no interpretation with the [FCE], but it appears that the claimant would only qualify for either a sedentary or light physical demand level based on the data presented" and that "the veracity of the FCE is noted and no real assessment as to real functional ability could be made."

The claimant said that his treating doctor sent him for an FCE on February 2, 2005. The FCE report of February 2, 2005, states that the claimant's occupation requires performance at the medium/heavy demand level; that the claimant demonstrated the ability to perform at the light/medium physical demand level; and that the claimant is not a candidate to return to his previous employment as a general laborer.

The self-insured appeals the following findings of fact and conclusions of law:

## FINDINGS OF FACT

8. During the qualifying period for the 1st quarter:

    A. Claimant was unemployed as a direct result of Claimant's impairment.

    B. Claimant had no ability to work.

    C. Claimant's Treating Doctor provided a narrative, which specifically explains how the injury causes claimant a total inability to work.

    D. [Peer review doctor] provided a medical record that opined Claimant has some ability to work but has little credibility.

    E. Claimant nor his Treating Doctor ever received [the peer review doctor's] opinions to be able to respond to or act upon them.

## CONCLUSIONS OF LAW

4. Claimant is entitled to [SIBs] for the 1st quarter.

With regard to the direct result criterion for SIBs, we conclude that the hearing officer's finding that the claimant was unemployed as a direct result of his impairment is supported by sufficient evidence and is not so against the great weight and preponderance of the evidence as to be clearly wrong and unjust.

With regard to the good faith criterion for SIBs, the self-insured contends that the treating doctor's reports are merely conclusory opinions and that the treating doctor's report of December 17, 2004, indicates some ability to work. We agree that the treating doctor's report of December 17, 2004, wherein the treating doctor indicates that the claimant would be able to attempt to work four hours a day or less, does indicate some ability to work. However, that report is several days after the end of the qualifying period and the treating doctor later clarified in his report of April 13, 2005, that during the qualifying period the claimant had no ability to work at all due to his work-related injury and explained that his opinion was based on the claimant's functional limitations due to severe pain. The treating doctor's April 13, 2005, report is consistent with his September 14, 2004, report, which was during the qualifying period. We conclude that the hearing officer's finding that the claimant's treating doctor provided a narrative report which specifically explained how the injury caused a total inability to work is supported by the evidence.

The self-insured contends that there are other records in evidence which show that the claimant was able to return to work during the qualifying period and references the peer review doctor's reports of July 9, 2003, and February 17, 2004; the RME doctor's reports of December 17, 2004, and January 10, 2005; the December 17, 2004, FCE report; the December 17, 2004, report of the treating doctor; and the FCE report of

February 2, 2005. The self-insured asserts that the peer review doctor's reports are evidence on the claimant's ability to work and should not be rejected as not credible simply because the treating doctor did not comment on the reports.

In the Background Information section of his decision, the hearing officer states that there are two records opining that the claimant has an ability to work and references the two reports from the peer review doctor. The hearing officer then quotes from Texas Workers' Compensation Commission Appeal No. 022544 (typographical error refers to 025544), decided November 12, 2002, wherein the Appeals Panel reaffirmed that a peer review doctor's report can be another record showing an ability to work, but that the hearing officer judges the weight and credibility of the evidence, and that the fact that a peer review doctor has not personally examined the claimant may make his opinion less credible.

The hearing officer also states that the peer review reports purportedly show that the claimant is able to return to work, but that there is no evidence that the claimant or his treating doctor ever received those reports, and that while the peer review reports opine that the claimant can do limited or sedentary work, the claimant cannot be expected to look for work based upon records neither he nor his doctor are aware of and cannot respond to. The hearing officer further states that there are no opinions given before the qualifying period that the claimant could work. The hearing officer states that the credibility of the (peer review) opinion is called into question because the other party cannot respond to it.

We note that there is no evidence as to whether the peer review doctor's reports were sent to the claimant or to the treating doctor; that the peer review doctor's reports do precede the qualifying period and state that the claimant can perform work in a limited capacity or sedentary capacity; and that the hearing officer does not mention the FCE reports or the RME doctor's reports dated December 17, 2004, and January 10, 2005, in the Background Information section of his decision nor in his findings of fact.

In Texas Workers' Compensation Commission Appeal No. 030823, decided May 22, 2003, the Appeals Panel noted that medical evidence from outside the qualifying period may be considered insofar as the hearing officer finds it probative of conditions in the qualifying period, and that in determining whether another record shows that the injured employee is able to return to work, factors such as a worsening of the employee's medical condition and when the other record was prepared in relation to the qualifying period could be considered. The Appeals Panel has stated that whether another record shows an ability to work is a question of fact for the hearing officer to resolve. Texas Workers' Compensation Commission Appeal No. 023218, decided February 3, 2003. The Appeals Panel has also stated that "in cases where a total inability to work is asserted and there are other records which on their face appear to show an ability to work, the hearing officer is not at liberty to simply reject those records as not credible without explanation or support in the record." Texas Workers' Compensation Commission Appeal No. 002196, decided October 24, 2000.

In the preamble for the adoption of Rule 130.102(d)(3), which was the SIBs no-ability-to work provision prior to its renumbering as Rule 130.102(d)(4) in November 1999, a comment was made that the medical records regarding the inability to work be from the treating doctor, or if from other than a treating doctor, that the treating doctor agree with the records or information. The Commission disagreed with that comment stating in part that requiring all the records to be from the treating doctor or agreed upon by the treating doctor does not allow the full evaluation of a person's true ability to work, and that the treating doctor is not the sole source of return to work information nor should the information be required to be approved by the treating doctor. Another commenter inquired whether an injured employee's obligation to look for work only begins when the injured employee has notice of a release to return to work. The Commission responded in part that the ability to work is something that can exist with or without medical records and is ultimately a decision of the finder of fact in the event of a dispute, and that the language of the provision is tied to the ability to work and not any "notice" requirement. 24 Tex. Reg. 406 (1999).

Based on the language in the preamble to the adoption of the SIBs no-ability-to work provision, which reflects that for purposes of that provision the treating doctor is not required to approve return-to-work information from other sources and that the provision is not tied to any notice requirement, we hold that the hearing officer erred in rejecting the peer review reports solely on the basis that there was no evidence that either the claimant or the treating doctor received those reports. It is apparent from the statements in the hearing officer's decision that the sole reason for making a finding that the peer review reports had little credibility was because there was no evidence that either the claimant or the treating doctor received the peer review reports and thus could not respond to them. While the hearing officer is the sole judge of the weight and credibility of the evidence under Section 410.165(a), the hearing officer's stated reason for rejecting the peer review reports constituted legal error as it is contrary to the Commission's interpretation of the no-ability-to work provision as stated in the preamble to the adoption of that provision. In addition, the hearing officer has not addressed the two FCE reports nor the reports of the RME doctor regarding work status, but has limited his finding regarding other records to just the peer review reports.

We reverse the hearing officer's finding that the claimant had no ability to work during the qualifying period for the first quarter and his decision that the claimant is entitled to SIBs for the first quarter, and we remand the case to the hearing officer for the hearing officer to make findings of fact with regard to whether other records show that the claimant was able to return to work during the qualifying period for the first quarter and for a determination on whether the claimant is entitled to SIBs for the first quarter.

## CONCLUSION

The hearing officer's decision that the claimant's IR is 20% is affirmed. We reverse the hearing officer's decision that the claimant is entitled to SIBs for the first

quarter and we remand the case to the hearing officer on the issue of entitlement to SIBs for the first quarter for further action consistent with this decision.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings pursuant to Section 410.202, as amended effective June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of time in which a request for appeal or a response must be filed.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

**(NAME)**
**(ADDRESS)**
**(CITY), TEXAS (ZIP CODE)**.

_____
Robert W. Potts
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge